

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/31/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2011	
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST SEVENTH STREET NORTH MANCHESTER, IN46962			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	<p>This visit was for the Investigation of Complaint IN00089382.</p> <p>Complaint IN00089382 - Substantiated, federal/state deficiencies related to the allegation are cited at F-281, F-323, and F-514.</p> <p>Survey date: April 25, 2011</p> <p>Facility number: 000485 Provider number: 155655 AIM number: 100291190</p> <p>Survey team: DeAnn Mankell, R.N.</p> <p>Census bed type: SNF: 13 SNF/NF: 108 NF: 21 Residential 82 NCC: 13 Total: 237</p> <p>Census payor type: Medicare: 19 Medicaid: 88 Other: 130 Total: 237</p> <p>Sample: 4</p>			F0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2011	
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST SEVENTH STREET NORTH MANCHESTER, IN46962			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0281 SS=D	<p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 28, 2011 by Bev Faulkner, RN</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>Based on record review and interview, the facility failed to ensure Certified Nurse Aides (CNAs) worked within their scope of practice; in that a CNA applied a hot rice pack to a resident's shoulder resulting in a second degree burn with a blister to the resident. This practice affected 1 of 1 resident in a sample of 4. CNA (identified as RSC #2) and Resident A.</p> <p>Findings included:</p> <p>1. Review of the "Indiana State Department of Health Division of Long Term Care Nurse Aide</p>			F0281	<p>Preparation and execution of this plan of correction in no way constitutes an admission or an agreement by Peabody Retirement Community of the truth or of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. Peabody Retirement Community reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis of the stated deficiency. This Plan of Correction serves as the allegation of compliance. Corrective action for resident A: 1) Policy related to application of moist/dry heat was changed to reflect that only therapy staff will be allowed to apply heat modalities to residents. How other residents</p>		04/26/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2011	
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST SEVENTH STREET NORTH MANCHESTER, IN46962			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Training Program dated July 1998 indicated.... Standard 14 Nurse Aide Scope of Practice. The nurse aide will perform only the tasks in the course standards and Resident Care Procedures manual. The nurse aide will not ... perform treatments...."</p> <p>During the facility tour on 4/25/11 at 11:07 A.M., with the ADON (Assistant Director of Nurses), she indicated Resident A had a sustained a burn from a rice pack in the past 3 to 4 weeks.</p> <p>Resident A's clinical record was reviewed on 4/25/11 at 2:30 P.M.</p> <p>Resident A's diagnoses included, but were not limited to, senile dementia, hypertension, osteoarthritis, hypothyroidism, bipolar, and osteoporosis.</p> <p>The clinical notes for Resident A had a note, dated 3/31/2011 at 8:15 A.M., with the following: "Nurse noted 1.8 cm (centimeter) x 2.5 cm</p>				<p>with potential to be affected were addressed:2) All residents having rice packs in their rooms had the new policy reviewed with them and the rice packs were removed from resident rooms.Measures/system changes made:3) Policy was amended.How corrective measures will be monitored:4) Nursing management has included compliance on daily rounds sheets and will monitor for the next six months to ensure compliance. The policy will be reviewed with all new nursing staff and SS will review with all new residents to ensure policy is enforced. No heat packs being discovered during rounds and no issues being brought up in the safety committee for six months, indicating 100% compliance is the criteria that is needed in order to stop the monitoring, otherwise it will continue until compliance is achieved.This statement of deficiencies and POC dated 4/25/11 will be reviewed by Peabody Retirement community QI/QA committee on May 25, 2011 and the Safety committee on May 18, 2011.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2011	
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST SEVENTH STREET NORTH MANCHESTER, IN46962			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>blister with erythema surrounding site on resident's R (right) shoulder at 0700 [7:00 A.M.] today.... Per RSC (resident service coordinator [a certified nurses' aid]), heated rice bag had been placed on resident's shoulder last night and resident had c/o (complained of) burning so bag was immediately removed. Redness was noted at the site last night, but there was no blister. when (sic) site palpated pt (patient) states, 'it hurts,' could not determine pain level from facial expression due to flat affect, no grimacing. No others s/s (signs/symptoms) of discomfort noted, no s/s infection noted...."</p> <p>Review of the Nurse Practitioner's progress note, dated 3/31/11, indicated "2o (second degree) burn. Apply Silvadene cream (a treatment for burns) to open blister/burn site bid (2 times a day) until healed. May give xtra (extra) dose of Tramadol (a pain medication) prn (an needed) pain."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2011	
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST SEVENTH STREET NORTH MANCHESTER, IN46962			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Review of the facility incident report, dated 3/31/11, indicated Resident A had a burn on her right shoulder which was 1.8 cm x 2.5 cm with a blister with erythema. The brief description was "RSC informed nurse that resident has a blister on her (R) shoulder. Per RSC heated rice bag was put on resident's shoulder last night (3/30) and resident had stated that it felt like it was burning. Rice bag was immediately removed, site was red but no blister was present at that time."</p> <p>The report indicated there were phone interviews conducted with the RSC's who had worked on the unit on 3/30/11. The interview with RSC #2 noted "she heated up a rice pack for resident shortly before lunchtime because she was c/o (complaining) of pain to the R shoulder. Stated she heated it up for 3 minutes, securely wrapped it up in a towel and placed it on her R shoulder."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2011	
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST SEVENTH STREET NORTH MANCHESTER, IN46962			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Review of the policy for "Moist Heat Application (Rice Packs) dated 5-04 and provided by the Administrator on 4/25/11 at 3:00 P.M., indicated "It is the policy of Peabody Retirement Community to use dry heat to relieve chronic pain and discomfort or in preparation for another treatment such as massage or stretching. Dry heat may be applied by a nurse as a nursing measure or with a physician's order."</p> <p>During an interview with RSC #2, who was a Restorative CNA, on 4/25/11 at 6:00 P.M., she indicated she had heated the rice pack in the microwave for 2 minutes and had wrapped it in a towel and placed it on Resident A's left shoulder while the resident sat on a couch in the unit's common area. She indicated she had also placed another rice pack on the resident's right groin. She indicated she had done this sometime between breakfast and lunch. She did not tell the nurse on the unit and she could not</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2011	
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST SEVENTH STREET NORTH MANCHESTER, IN46962			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0323 SS=G	<p>remember if she had told one of the RSC's. She did not remain on the unit after she had placed the rice packs. She indicated she had placed many rice packs over the 6 years she had worked at the facility. She indicated she had been told how to heat the rice packs by other staff members in the past.</p> <p>During an interview with the Administrator on 4/25/2011 at 5:30 P.M., she indicated the facility's policy had not been followed.</p> <p>This federal tag relates to complaint IN00089382.</p> <p>3.1-35(g)(1)</p>						
	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on record review and interview, the facility failed to ensure the safe use of rice packs for</p>			F0323	<p>Corrective action for resident A:1) Resident was assessed immediately by nurse after being informed by RSC that resident A</p>		04/26/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2011	
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST SEVENTH STREET NORTH MANCHESTER, IN46962			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>treating a resident complaints of pain for 1 of 2 residents reviewed for safe use of rice packs in the sample of 4. This failure resulted in Resident A sustaining a second degree burn to the shoulder. (Resident A).</p> <p>Findings included:</p> <p>1. During the facility tour on 4/25/11 at 11:07 A.M., with the ADON (Assistant Director of Nurses), she indicated Resident A had a sustained a burn from a rice pack in the past 3 to 4 weeks.</p> <p>Resident A's clinical record was reviewed on 4/25/11 at 2:30 P.M.</p> <p>Resident A's diagnoses included, but were not limited to, senile dementia, hypertension, osteoarthritis, hypothyroidism, bipolar, and osteoporosis.</p> <p>Review of the quarterly MDS (minimum data set) assessment, dated 3/11/11, indicated a score of 8</p>				<p>had a blister on her right shoulder. Nurse practitioner was contacted and she gave treatment order for Silvadene cream on 3/31/11 to open blister/burn twice daily until healed. Also, ordered extra dose of Tramadol for pain prn. Compliance date: 3/31/11How other residents with potential to be affected were addressed:2a) Did 100% audit on all residents who were using rice packs in the healthcare center. Assessed skin head to toe. Found no other burn injuries to these residents. 2b) Pulled all rice packs immediately from resident's rooms after explaining policy change.2c) Updated all nursing "hot sheets" for daily nursing charting to include any substantial skin issues to be charted on every shift until healed in nurses' notes. Compliance date: 3/31/11Measures/system changes made:3a) All staff was informed on 4/1/11 that no heat, dry or moist, would be performed by any nursing staff. The PRC therapy department will be the only staff who may apply dry/moist heat to residents with heart modality physician order only.3b) When a resident desires heat therapy, staff will give the resident other treatment options such as massage, ointments/gels as ordered by the physician, or referral to therapy for further assessment. Compliance date: 4/1/11How corrective measures</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2011	
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST SEVENTH STREET NORTH MANCHESTER, IN46962			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>of 15 for cognitive patterns which indicated Resident A was moderately cognitively impaired.</p> <p>The clinical record lacked any nurses' notes from 3/25/11 until 3/31/11.</p> <p>The clinical notes for Resident A had a note, dated 3/31/2011 at 8:15 A.M., with the following: "Nurse noted 1.8 cm (centimeter) x 2.5 cm blister with erythema surrounding site on resident's R (right) shoulder at 0700 today.... Per RSC (resident service coordinator [a certified nurses' aid]), heated rice bag had been placed on resident's shoulder last night and resident had c/o (complained of) burning so bag was immediately removed. Redness was noted at the site last night, but there was no blister. when (sic) site palpated pt (patient) states, 'it hurts,' could not determine pain level from facial expression due to flat affect, no grimacing. No others s/s (signs/symptoms) of discomfort noted, no s/s infection noted...."</p>				<p>will be monitored:4) The Director of Nursing or her designee will complete rounds daily and document findings to ensure all significant skin issues are continuing to be charted on until resolved and placed on the "hot sheets" daily for the next six months. Significant skin issues will be reviewed weekly at the Risk meeting. No documentation being determined to be missing after six months, and thus indicating 100% compliance is the criteria that needs to be met in order to stop the monitoring, otherwise it will continue until compliance is achieved. This statement of deficiencies and POC dated 4/25/2011 will be reviewed by Peabody Retirement community QI/QM committee on May 25, 2011 and at the Safety committee on May 18, 2011.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2011	
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST SEVENTH STREET NORTH MANCHESTER, IN46962			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Review of the nurse practitioner's progress note, dated 3/31/11, indicated "2o (second degree) burn. Apply Silvadene cream (a treatment for burns) to open blister/burn site bid (2 times a day) until healed. May give xtra (extra) dose of Tramadol (a pain medication) prn (an needed) pain."</p> <p>Review of the physician's order indicated the lack of an order for a rice pack.</p> <p>Review of the MAR (Medication Administration Record)/TAR (Treatment Admission Record) for March 2011 indicated the lack of documentation of the use of the rice pack.</p> <p>Review of the facility incident report, dated 3/31/11, indicated Resident A had a burn on her right shoulder which was 1.8 cm x 2.5 cm with a blister with erythema. The brief description was "RSC informed nurse that resident has a</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2011	
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST SEVENTH STREET NORTH MANCHESTER, IN46962			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>blister on her (R) shoulder. Per RSC heated rice bag was put on resident's shoulder last night (3/30) and resident had stated that it felt like it was burning. Rice bag was immediately removed, site was red but no blister was present at that time."</p> <p>The report contained a statement made by RSC #1 indicated "On 3/30/11 res. had a rice pack on right shoulder @ lunch. Stated that she thought it had burned her. Res shoulder was just a little red so we took it off. This morning on 3/31/11 while getting the res ready for her shower, I had seen it was blistered and reported it to the nurse."</p> <p>There were phone interviews conducted with the RSC's who had worked on the unit on 3/30/11. The interview with RSC #2 noted "she heated up a rice pack for resident shortly before lunchtime because she was c/o (complaining) of pain to the R shoulder. Stated she heated it</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2011	
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST SEVENTH STREET NORTH MANCHESTER, IN46962			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>up for 3 minutes, securely wrapped it up in a towel and placed it on her R shoulder."</p> <p>Review of the policy for "Moist Heat Application (Rice Packs), dated 5-04, and provided by the Administrator on 4/25/11 at 3:00 P.M., indicated "It is the policy of Peabody Retirement Community to use dry heat to relieve chronic pain and discomfort or in preparation for another treatment such as massage or stretching. Dry heat may be applied by a nurse as a nursing measure or with a physician's order." The procedure was 1. Use microwave in Medication Room only to heat rice packs. Place rice pack in microwave on high for 1 1/2 - 2 minutes. 2. Knead rice pack to ensure equal distribution of the heat. 3. Place rice pack in towels, using as many as necessary for the comfort of the resident.... 5. Assess skin prior to heat pack application and document assessment on Hot/Cold Pack Application Flow Sheet which will be placed on the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2011	
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST SEVENTH STREET NORTH MANCHESTER, IN46962			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>TAR.... 8. After 5 minutes, the clinical staff nurse will remove the pack and inspect the skin for redness or blistering. A pinkish hue is normal. 9. At the end of the treatment, the area where the heat was applied will be inspected. The skin assessment and response to treatment will be recorded on the Hot/Cold Pack Application Flow Sheet."</p> <p>During an interview with RSC #2, who was a Restorative CNA, on 4/25/11 at 6:00 P.M., she indicated she had heated the rice pack in the microwave for 2 minutes and had wrapped it in a towel and placed it on Resident A's left shoulder while the resident sat on a couch in the unit's common area. She indicated she had also placed another rice pack on the resident's right groin. She indicated she had done this sometime between breakfast and lunch. She did not tell the nurse on the unit and she could not remember if she had told one of the RSC's. She did not remain on the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2011	
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST SEVENTH STREET NORTH MANCHESTER, IN46962			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>unit after she had placed the rice packs. She indicated she had placed many rice packs over the 6 years she had worked at the facility. She indicated she had been told how to heat the rice packs by other staff members in the past.</p> <p>During an interview with the Administrator on 4/25/2011 at 5:30 P.M., she indicated the facility had discontinued the use of the rice packs as it was not possible to ensure the temperature of the rice packs.</p> <p>This federal tag relates to complaint IN00089382.</p> <p>3.1-45(a)(1)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/25/2011	
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST SEVENTH STREET NORTH MANCHESTER, IN46962			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0514 SS=D	<p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to have a complete record of the care of a resident with the treatment of a rice pack for 1 of 1 resident with the use of a rice pack in a sample of 4 (Resident A).</p> <p>Findings included:</p> <p>1. Review of the policy for "Moist Heat Application (Rice Packs) dated 5-04 and provided by the Administrator on 4/25/11 at 3:00 P.M. indicated "It is the policy of Peabody Retirement Community to use dry heat to relieve chronic pain and discomfort or in preparation for another treatment such as massage or stretching. Dry heat may be applied by a nurse as a nursing</p>		F0514	<p>Corrective action for resident A:1) Updated all nursing "hot sheets" for daily nursing charting to include all substantial skin issues to be charted on every shift until healed in nurses' notes.How other residents with potential to be affected were addressed:2) Nurse managers reviewed all "hot sheets" to ensure any current resident with substantial skin issue was included .Measures/system changes made:3) Updated all nursing "hot sheets" for daily nursing charting to include all substantial skin issues to be charted on every shift until healed in nurses' notes.How corrective measures will be monitored:4) The Director of Nursing or her designee will complete rounds daily and document findings to ensure all significant skin issues are continuing to be charted on until resolved and placed on the "hot sheets" daily for the next six months. Significant skin issues will be reviewed weekly at the Risk meeting. No</p>		04/26/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2011	
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST SEVENTH STREET NORTH MANCHESTER, IN46962			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>measure or with a physician's order." The procedure was "5. Assess skin prior to heat pack application and document assessment on Hot/Cold Pack Application Flow Sheet which will be placed on the TAR. 9. At the end of the treatment, the area where the heat was applied will be inspected. The skin assessment and response to treatment will be recorded on the Hot/Cold Pack Application Flow Sheet."</p> <p>During the facility tour on 4/25/11 at 11:07 A.M., with the ADON (Assistant Director of Nurses), she indicated Resident A had a sustained a burn from a rice pack in the past 3 to 4 weeks.</p> <p>Resident A's clinical record was reviewed on 4/25/11 at 2:30 P.M.</p> <p>Resident A's diagnoses included, but were not limited to, senile dementia, hypertension, osteoarthritis, hypothyroidism, bipolar, and osteoporosis.</p>				<p>documentation being determined to be missing after six months, thus indicating 100% compliance, is the criteria that needs to be in order to stop the monitoring, otherwise it will continue until compliance is achieved. This statement of deficiencies and POC dated 4/25/2011 will be reviewed by Peabody Retirement community QI/QM committee on May 25, 2011 and at the Safety committee on May 18, 2011.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2011	
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST SEVENTH STREET NORTH MANCHESTER, IN46962			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>The clinical record lacked any nurses' notes from 3/25/11 until 3/31/11.</p> <p>The TAR and MAR for March 2011 lacked any assessment before or after the use of the rice pack.</p> <p>The clinical record lacked a Hot/Cold Pack Application Flow Sheet.</p> <p>The clinical notes for Resident A had a note, dated 3/31/2011 at 8:15 A.M., with the following: "Nurse noted 1.8 cm (centimeter) x 2.5 cm blister with erythema surrounding site on resident's R (right) shoulder at 0700 [7:00 A.M.] today.... Per RSC (resident service coordinator [a certified nurses' aid]), heated rice bag had been placed on resident's shoulder last night and resident had c/o (complained of) burning so bag was immediately removed. Redness was noted at the site last night, but there was no blister. when (sic) site palpated pt (patient)</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/31/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2011	
NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST SEVENTH STREET NORTH MANCHESTER, IN46962			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>states, 'it hurts,' could not determine pain level from facial expression due to flat affect, no grimacing. No others s/s (signs/symptoms) of discomfort noted, no s/s infection noted...."</p> <p>During an interview with the Administrator on 4/25/2011 at 5:30 P.M., she indicated there were no additional notes about the rice pack.</p> <p>This federal tag relates to complaint IN00089382.</p> <p>3.1-50(a)(1)</p>						